Medical abortion still not available in most countries

Annabel Ferriman *BMJ*

The mifepristone pill is a safe and effective method of abortion, which many women find more acceptable than the surgical alternative. Yet its use throughout the world is limited to a minority of countries, most of which already have a relatively safe abortion record, delegates at a London conference were told last week.

Ms Beverly Winikoff, programme director of the Population Council, a research organisation based in New York, said that rates of unsafe abortion varied widely throughout the world. The lowest rates, of 0-4 per 1000 women of reproductive age, were in the United States, western Europe, Australia, and China, and the highest rates, of more than 25 per 1000, were in the former Soviet Union, parts of Africa, South East Asia, and South America (see map).

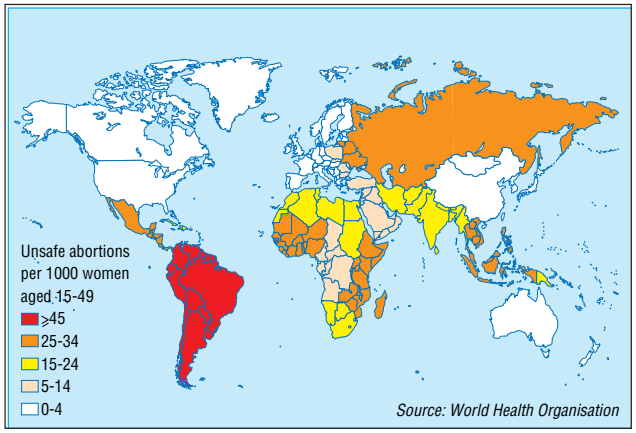
But despite the fact that between 70 000 and 100 000 women a year were dying from illegal and unsafe abortion, there were no plans for medical abortion to be adopted in the parts of the world with the highest death rates. Dr George Brown of the Population Council said that the council was worried, in the light of the number of unsafe abortions, that the World Health Organisation was cutting back on its abortion activities.

Mifepristone, a drug first synthesised in France in 1980, which has subsequently been shown to have a good safety record, is approved and on the market in the United Kingdom, Sweden, France, Israel, and China. It has also been approved by the European Medicines Evaluation Agency for eight more countries in western Europe but is still waiting for national approval in those countries. The US Food and Drug Administration is expected to give it a full licence next year.

Ms Winikoff told the conference, which was organised jointly by the Population Council and the UK Family Planning Association, that China had made the most use of the drug. It has been estimated that more than 20 million abortions had been carried out with mifepristone in China over the past seven years.

A high proportion of women using the drug in clinical trials expressed satisfaction with the drug and said that they would use it again or recommend it to friends. Features that they liked were:

- It seemed a more natural and feminine way to have an abortion (being similar to having a period or a miscarriage);
- It avoided an anaesthetic;
- It was more compatible with their lifestyle if they were looking after children, as it only required a three hour stay in a hospital or clinic.



Distribution of unsafe abortion (no regions with range 35–44)

Features that they did not like included the pain, the bleeding, the uncertainty about whether it had worked, and the many visits that they had to make to the clinic or hospital. In most cases women have to make three visits: first to be given mifepristone; three days later to be given a prostaglandin (usually misoprostol or gemeprost), and 14 days later to check that the abortion is complete. Ms Winikoff said that the drug had a success rate of 98% in clinical trials in the United States.

Speakers deplored the time it was taking to get the drug on the market in Austria, Germany, Greece, the Netherlands, Spain, and Switzerland, despite the fact that it had had the approval of the European Medicines Evaluation Agency. Dr André Ulman, of the pharmaceutical company, HRA Pharma, Paris, thought that this was because the drug was made and marketed by a relatively small firm, Exelgyn in Paris. Exelgyn's turnover is about £2.5m ($4m) a year.

Kate Paterson, consultant community gynaecologist at St Mary's Hospital, London, said that England was dragging behind Scotland in adopting the abortion pill. In Scotland 27% of all abortions were medical ones, whereas in England the proportion was only 5.6%. □

Study into medical errors planned for the UK

Jane Smith *BMJ*

Investigators are seeking £1.2m to fund research into injuries caused by medical mismanagement in UK hospitals. Similar studies in New York, Colorado and Utah, and Australia have shown rates of adverse events caused by medical mismanagement of 3.7-10.6% of all admissions. A pilot study in London showed a rate of 6.7%.

The British study will use methods similar to those used in the US and Australian studies and the same definition of an adverse event—an injury caused by medical mismanagement that prolongs admission or causes disability at discharge.

Speaking at a meeting in London last week to propose the study, Dr Eric Thomas, of the University of Texas in Houston and an investigator of the Colorado and Utah study, said that errors in medicine were a major public health problem, representing the seventh largest cause of death in the United States.

He said that the studies had led to improvements in patients' safety. Changes that had reduced the levels of medical injury included the introduction of computerisation in the ordering of tests and prescribing of antibiotics and the attendance of pharmacists at rounds on intensive care units.

The British pilot study, run by the clinical risk unit at University College London and performed at the Whittington Hospital, London, showed that the quality of records was good enough to identify adverse events and that the review methods used in the United States and Australia could be adapted to a British context.

Dr Graham Neale, one of the investigators, said that the aim of both the pilot and the main study was to identify areas of practice that could be improved relatively easily and so reduce medical errors.

The pilot study screened 480 records and found 32 adverse events—including diagnostic errors, operative mishaps, adverse drug reactions, and problems with discharge; over half were judged preventable.

The proposed national study would include 20 hospitals and review 10 000 records. The objectives of the study, explained Dr Charles Vincent, head of the clinical risk unit, were to provide information on the nature, incidence, and cost of adverse events and thus provide a baseline for clinical governance and a baseline cost against which intervention strategies could be costed.

In the pilot study each adverse event had caused an average of six extra days spent in hospital. If the figures in the pilot study were applied to England, he said, the cost of these extra days alone would amount to £730m ($1168m). □